

Please see Web Announcement 999 dated October 19, 2015, for instructions to provider types 30, 38, 39, 48, 55, 57, 58, 59 and 83 on using ICD-10 codes effective on claims with dates of service on or after October 1, 2015.



January 13, 2012

Announcement 436

Allscripts-Payerpath Users: Claims Must Include ICD-9-CM/Diagnosis Codes Per 5010 Regulations

Effective January 1, 2012, all claims electronically submitted through Allscripts/Payerpath for reimbursement must include an ICD-9-CM/diagnosis code to be in compliance with 5010 federal regulations. Claims submitted on and after January 1, 2012, that are missing an ICD-9-CM/diagnosis code are being rejected by the system.

The following provider types previously were not required to include ICD-9-CM/diagnosis codes on claims: Home and Community Based Waivers, Personal Care Services, Intermediary Service Organizations and Adult Day Health Care Providers (provider types 30, 38, 39, 48, 57, 58 and 83).

To ensure timely and accurate payment of claims, affected providers should use the ICD-9-CM/diagnosis codes supplied by the recipient's qualified medical professional. If that information cannot be obtained, it is acceptable for provider types 30, 38, 39, 48, 57, 58 and 83 to use the ICD-9-CM/diagnosis code **V604** ("No other household member able to render care"). Do not use decimal points in diagnosis codes when submitting claims through Allscripts/Payerpath. These providers who have claims that have been rejected for missing an ICD-9-CM/diagnosis code may resubmit the claims electronically in accordance with the above information.